September 2014

Montana Central Tumor Registry Newsletter

Montana Cancer Control Programs
Chronic Disease Prevention & Health Promotion Bureau

Surgeon General issues call to action to prevent skin cancer

Skin cancer rates rising: most cases are preventable

Skin cancer, the most commonly diagnosed cancer in the United States, is a major public health problem that requires immediate action, according to a new Call to Action released today by the U.S. Surgeon General.

Even though most skin cancers can be prevented, rates of skin cancer, including melanoma, are increasing in the United States. Nearly 5 million people in the U.S. are treated for skin cancer every year, at an average annual cost of $8.1 billion. It is also one of the most common types of cancer among U.S. teens and young adults.

A key message in today's report is that although people with lighter skin are at higher risk, anyone can get skin cancer—and it can be disfiguring, even deadly. Over the last three decades, the number of Americans who have had skin cancer is estimated to be higher than the number for all other cancers combined.

"While many other cancers, such as lung cancer, are decreasing, rates of melanoma -- the deadliest form of skin cancer -- are increasing," said Assistant Secretary for Health Howard K. Koh, M.D., M.P.H. "As a skin oncologist who worked in this field for many years, I have cared for both the young and old with skin cancers. Almost all of these cancers were caused by unnecessary ultraviolet radiation exposure, usually from excessive time in the sun or from the use of indoor tanning devices."

Melanoma is the deadliest form of skin cancer. Each year, more than 63,000 new cases are diagnosed in the U.S. and nearly 9,000 people die from this disease. Rates of melanoma increased more than 200 percent from 1973 to 2011. Melanoma is also one of the most common types of cancer among U.S. teens and young adults.

According to research cited in the Call to Action, more than 400,000 cases of skin cancer, about 6,000 of which are melanomas, are estimated to be related to indoor tanning in the U.S. each year. Currently, as many as 44 states plus the District of Columbia have some type of law or regulation related to indoor tanning, but nearly one out of every three white women aged 16 to 25 years engages in indoor tanning each year.

"Tanned skin is damaged skin, and we need to shatter the myth that tanned skin is a sign of health," said Acting Surgeon General Boris D. Lushniak, M.D., M.P.H. "When people tan or get sunburned, they increase their risk of getting skin cancer later in life."

The Surgeon General's Call to Action helps to educate consumers by providing everyday steps they can take to lead healthy and active lives while being outdoors. These steps include wearing protective gear (such as a hat, sunglasses, and other protective clothing) and seeking shade along with the use of a broad-spectrum sunscreen with a sun protection factor (SPF) of 15 or higher to protect any exposed skin, especially during midday hours.

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Cancer Surveillance & Epidemiology Program Staff

Laura Williamson, MPH
Program Manager
(406) 444-0064
lwilliamson@mt.gov

Debbi Lemons, RHIA, CTR
Coordinator, Montana Central Tumor Registry
(406) 444-6786
dlemons@mt.gov

Diane Dean, MS, CTR
Data Control Specialist
(406) 444-6710
ddean@mt.gov

Paige Johnson, BS, CTR
Data Control Specialist
(406) 444-6709
paigejohnson@mt.gov

Valerie Weedman
Logistics Coordinator
(406) 444-5442
vweedman@mt.gov

FAX: (406) 444-6557

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THE MCTR STAFF

Debbi Lemons: I have been Coordinator for the Montana Central Tumor Registry for 25+ years. I still love learning new things and am amazed at how everything has drastically changed in the last 25 years. I can't believe our summer is over, it was a busy one. Work is pretty exciting but it's the kiddos that keep us busy! My husband, Jeff, and two girls, Laci (8) and Jessa (4) spent a vacation in Cortez, CO visiting Jeff's family and as soon as we got home, turned around and spent a few days up near Glacier Park in Hungry Horse. We spent another week near Glacier with extended family celebrating several wedding anniversaries. For work, I traveled to Atlanta, GA and will be heading to King of Prussia, PA soon to attend the RMCDS annual meeting. When home, I love cooking and quilting.

Laura Williamson: I have been a program manager and epidemiologist with the Montana Cancer Control Programs for the last three years. Managing the registry keeps me on my toes—I am constantly learning new things about data collection or cancer epidemiology. This summer flew by (as it always does)! I was able to leave the country twice. First I went to Canada for the annual NAACCR conference. Then I went to Amsterdam, The Netherlands to visit a friend. When I wasn't traveling, I enjoyed mountain biking with my husband at home in Helena.

Diane Dean: I have been with the Central Registry since 1989 first as a follow-up specialist and since 2000 as a quality assurance technician. I earned my CTR in the fall of 1999. This summer has been so much fun teaching my granddaughter Aurora about gardening and how to grow vegetables. She loves carrots and peas because she can pick them herself. She also learned that grandma's roses and flowers are off limits. She is a little disappointed that most vegetables are planted in the spring; grow in the summer, and a picked in the fall.

Valerie Weedman: I have been the Logistics Coordinator for the Cancer Section for almost 7 years now. I love the constant challenge of all the different programs that I get to work with. I have a 12 year old daughter that is the light of my life and we keep very active with many activities including Girl Scouts and sports. This past summer we were able to enjoy a wonderful trip to Glacier. The continental divide has a way of bringing life back into focus.

Paige Johnson: I have been a Quality Assurance Technician with the MCTR for nine years. Time Flys!! This summer my boys (Gus 3 and Creek 2) , my husband and I traveled to Glacier and stayed in the little red caboose at Essex, MT. Our July was spent repairing old haying equipment, but we finally got the field cut. We are currently building a new home and hoping for a speedy process!

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"We want all Americans to lead healthy, active lives," Dr. Lushniak said, "We all need to take an active role to prevent skin cancer by protecting our skin while being outdoors and avoiding intentional sun exposure and indoor tanning."

The report calls on all sectors of Americans society, including the business, health care, education, government and nonprofit sectors, as well as families and individuals, to do more. Examples include communities providing shade in outdoor settings, health care providers counseling patients on the importance of using sun protection, and educational institutions discouraging indoor tanning.

Skin Cancer as a Major Public Health Problem

In 2009, the World Health Organization (WHO) classified indoor tanning devices as Class I human carcinogens on the basis of strong evidence linking indoor tanning to increased risk of skin cancer.[26] A 2014 meta-analysis estimated that more than 400,000 cases of skin cancer may be related to indoor tanning in the United States each year: 245,000 basal cell carcinomas, 168,000 squamous cell carcinomas, and 6,000 melanomas.[41] Initiating indoor tanning at younger ages appears to be more strongly related to lifetime skin cancer risk, possibly because of the accumulation of exposure over time from more years of tanning.[42-45]

Source: Read the Call to Action to learn how to prevent skin cancer at www.surgeongeneral.gov.

AJCC TNM Staging Timeline for Transition

After careful consideration the American Joint Committee on Cancer (AJCC), Centers for Disease Control and Prevention (CDC), the Commission on Cancer (CoC), and the National Cancer Institute (NCI) have determined that it is not feasible to continue support of Collaborative Staging beyond diagnosis year 2015. Beginning with cases diagnosed in 2016 support of Collaborative Stage will cease and CDC, CoC and NCI will transition to direct coding of the AJCC TNM staging. Direct coding of AJCC TNM (clinical and pathological) along with the careful collection of clinically significant biomarkers and prognostic factors and directly assigned Summary Stage will provide our programs with a more precise and stable method for the collection of staging data that is positioned to keep pace with future medical advances. 2014 and 2015 will be a transition period for all of us. During this transition the Collaborative Stage v2.05 Data Collection System will be used. At the same time the AJCC, CDC, CoC, NCI and CCCR will devote resources and support for training and other activities to ensure the continued collection of high quality data.

Source: American Joint Committee on Cancer.| Email: csv2@facs.org

Note: Beginning in 2015 the MCTR will be adding AJCC TNM Staging to the Visual Edit Feedback Reports.

Check out http://www.cancerregistryeducation.org/tnm-ss-resources for TNM and SS Resources

Certificate of Excellence Recipients

The following facilities received a certificate for the 2014 Second Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

Facility	City
Physicians:	
Yellowstone Dermatology	Billings
Rogers Dermatology	Bozeman
Advanced Dermatology of Butte	Butte
Dermatology Assoc of Great Falls	Great Falls
Helena Dermatology	Helena
Associated Dermatology	Helena
Dermatology Provider of Missoula	Missoula
Hospitals:	
Billings Clinic	Billings
St. Vincent Healthcare	Billings
St. James Hospital	Butte
Teton Medical Center	Choteau
Rosebud Health Center	Forsyth
Frances Mahon Deaconess Hospital	Glasgow
Glendive Medical Center	Glendive
Sletten Cancer Center	Great Falls
St Peters Hospital	Helena
Kalispell Regional Medical Center	Kalispell
Central Montana Medical Center	Lewistown
St. Patrick Hospital	Missoula
St. Joseph Medical Center	Polson
Ruby Valley Hospital	Sheridan
Broadwater Health Center	Townsend
Pathology:	
Yellowstone Path Institute	Billings

Coding Grade for Prostate 2014+

Prostate (site: prostate excluding lymphomas; CS schema: prostate)
Use the highest Gleason score from the biopsy/TURP or prostatectomy/autopsy. Use a known value over an unknown value. Exclude results from tests performed after neoadjuvant therapy began. This information is collected in CSv2 SSF 8 (Gleason score from biopsy/TURP) and SSF 10 (Gleason score from prostatectomy/autopsy) as stated below. Use the table below to determine grade even if your registry does not collect these SSFs. If you collect these SSFs, the information could be converted into the grade field automatically.
Usually prostate cancers are graded using Gleason score or pattern. Gleason grading for prostate primaries is based on a 5-component system (5 histologic patterns). Prostatic cancer generally shows two main histologic patterns. The primary pattern, the pattern occupying greater than 50% of the cancer, is usually indicated by the first number of the Gleason grade, and the secondary pattern is usually indicated by the second number. These two numbers are added together to create a pattern score, ranging from 2 to 10. If there are two numbers, assume that they refer to two patterns (the first number being the primary pattern and the second number the secondary pattern), and sum them to obtain the score. If only one number is given on a particular test and it is less than or equal to 5 and not specified as a score, do not use the information because it could refer to either a score or a grade. If only one number is given and it is greater than 5, assume that it is a score and use it. If the pathology report specifies a specific number out of a total of 10, the first number given is the score. Example: The pathology report says Gleason 3/10. The Gleason score would be 3.

Historical perspective on long term trends in prostate grade: The relationship of Gleason score to grade changed for 1/1/2014+ diagnoses in order to have the grade field in sync with AJCC 7th ed. Analysis of prostate grade before 2014 based solely on the grade field is not recommended. In Collaborative Stage (CS), Gleason score was originally coded in CSv1 in one field (SSF 6) and then it was split into two fields in CSv2 based on the tissue used for the test: needle biopsy/TURP (SSF 8) and prostatectomy/autopsy (SSF 10). For trends using data back to 2004, if one collected the various CS Gleason scores, one could design a recode to have the same criteria as the data collected 2014+. The original grade field would NOT be changed, but for analyses this recode could be based on the CS SSFs and the original grade code.

Historic Perspective

Description						
Gleason Score	**CS Code**	**Grade Code**	**AJCC 7th**	**SEER 2003-2013**	**AJCC 6th**	**Seer prior 2003**
2	002	1	G1	G1	G1	G1
3	003	1	G1	G1	G1	G1
4	004	1	G1	G1	G1	G1
5	005	1	G1	G2	G2	G2
6	006	1	G1	G2	G2	G2
7	007	2	G2	G3	G3	G2
8	008	3	G3	G3	G3	G3
9	009	3	G3	G3	G3	G3
10	010	3	G3	G3	G3	G3

Source http://seer.cancer.gov/tools/grade/